change consisted of a feeling of irritation at the site of the recent vaccination. This persisted for a couple of days and then the appearance of the rash was noticed on the hands and arms. I saw the patient 24 hours after the rash made its appearance and found its distribution as follows: the hands and fingers, both palmar and dorsal surfaces, the front and back of the forearms, and to a much less extent the upper arms. On the lower limbs the plantar and dorsal surfaces of the feet were affected and the adjoining portions of the legs, whilst the rash was present, though less profuse, on the thighs. In addition there were an isolated collection of papules over the lower part of the sternum and a few papules along the border of each pinna. In general the rash may be described as of a papulo-urticarial character, the papular appearance being most marked on the backs of the hands and fingers, a feature which had undoubtedly occasioned the suspicion of small-pox. An examination of these parts alone was, in fact, very suggestive of this disease. There were, however, no rash on the face, no accompanying pyrexia, and, as I have said, no history of recent acute illness. The papules, which were also present on the feet, were bright red in colour, about one or two lines in diameter, circular, and faded on pressure; they were softer than those met with in variola and exhibited a tendency to run together in patches. On the palms and palmar aspect of the fingers they formed bright red, discrete, tender macules, not raised but still round, and especially in the former situation were as much as from two to three lines in diameter. On the arms and legs the spots were soft, flat-topped, in general rather of an urticarial character, varying in size from one to three lines and everywhere accompanied by itching. Many spots had a narrow inflammatory areola but the surrounding redness and œdema were best marked on the pinnæ. In the centre of a few there was a minute scab and on the surface of some others an appearance as though vesiculation was beginning, but both of these manifestations I attributed to the scratching, squeezing, or rubbing to which the patient resorted on account of the irritation. The further course of the eruption was absolutely unlike that of variola as there was no steady progress to vesiculation and pustulation—on the contrary, the spots tended to coalesce over considerable areas, forming a uniform erythema, and then faded.

The interest in the case lies not only in the fact that it was mistaken for small-pox but further in the late appearance of the eruption after vaccination. In this instance a full month elapsed, though, according to Dr. T. D. Acland in Clifford Allbutt's "System of Medicine," post-vaccinal eruptions make their "first appearance between the ninth and fifteenth days," being "always contemporaneous with vaccination."

Manchester.

A CASE OF NUTMEG POISONING.

BY ROBERT A. PITTER, L.S.A.

QUITE recently I was called during the night to see a young woman who was stated to be "in a fit." I found her in a collapsed condition, muttering unintelligibly; her extremities were clammy, her pulse was hardly perceptible, and her pupils were somewhat dilated and reacted feebly to light. The symptoms were suggestive of alcoholic poisoning but her breath smelt unmistakeably of nutmeg and I then elicited that she had taken a whole nutmeg, grated, in a wineglassful of gin an hour or so previously. On asking her friends why she had done this I was told that "she was so afraid of having another child." It appeared that the catamenia had been delayed two weeks and, dreading pregnancy, she had taken the advice of some female friend with the result above mentioned. I afterwards made some inquiries and learned that there is a prevailing impression among the domestic servant class that nutmeg is an emmenagogue, although such a large dose is perhaps unusual. Her general condition improving I contrived to empty her stomach of its contents. She remained in muttering delirium throughout the night and slept heavily nearly all the next day, when she awoke apparently recovered. The catamenia followed, accompanied by much pain.

I should be grateful to any reader of THE LANCET for information as to other cases in which toxic effects have been produced by this spice.

Tottenham.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

ST. GEORGE'S HOSPITAL.

TWO CASES OF INTESTINAL OBSTRUCTION.

(Under the care of Mr. G. R. TURNER.)

THE former of the following two cases is a very striking instance of the benefit resulting from laparotomy in tuberculous peritonitis and it is especially valuable as it demonstrates clearly the rapid removal of tubercles deposited in the peritoneum. It is very rarely, indeed, that an opportunity is afforded of seeing the peritoneum soon after a laparotomy for tuberculous peritonitis. Although no satisfactory explanation has been given of the way in which this treatment acts, yet there can be no doubt about the satisfactory character of the results. F. Treves estimated[1] the mortality directly due to the operation as only 2·5 per cent.; the percentage of permanent recoveries is difficult to state with any exactness but Hartmann and Aldibert[2] claimed that 46 cases recovered out of 48. Those cases are the most satisfactory in which no other organs are affected with tubercle. The incident in this case of the retention of a Murphy's button is one by no means rare; it is especially frequently met with when a portion of the bowel has been short-circuited. It is very rare for the button to do any harm when thus retained and in most cases it passes ultimately spontaneously. The second case raises the question as to the desirability of colectomy in intestinal obstruction produced by a new growth. Each case must be decided on its merits. If the general condition of the patient will permit it a primary resection of the affected portion of bowel with anastomosis of the healthy intestine is certainly best, for the risk of a second operation is avoided; but if the patient is much collapsed it is better to do a colostomy and to postpone to a subsequent occasion the resection of the bowel.

CASE 1. *Intestinal obstruction due to tuberculous peritonitis; anastomosis of the ileum with the transverse colon; recovery, with disappearance of all tubercle within 45 days of operation.*—A girl, aged 11 years, was admitted into St. George's Hospital on May 14th, 1901, with the following history. Five days previously she had been attacked with sudden abdominal pain, frequent vomiting, and the passage of blood-stained motions. The child had been in bad health for several months. She was a thin, dark little girl of the fine tuberculous type and was flushed and looked very ill. Her tongue was covered with a brown fur; the pulse was 142 and weak and the temperature was 98° F. The abdomen was moderately distended and moved well on respiration. Nothing could be felt per rectum which contained some slimy mucus. In the right iliac fossa a mass of about the size of an orange could be distinctly felt. It was dull on percussion and tender. When she was placed under an anæsthetic some enlarged glands could be distinctly felt in this situation.

The abdomen was opened in the middle line. A quantity of enlarged tuberculous glands were found scattered throughout the mesentery and the peritoneum generally was studded with miliary tubercle. The lower ileum was enormously distended, injected, and vascular, whilst the ascending colon was collapsed and empty. In the right iliac fossa, in addition to some enlarged tuberculous glands, there was a large mass of matted intestine which included the cæcum and appendix, looking like a very firm intussusception with complete obstruction. As it seemed impossible to reduce this and as in the child's precarious condition it was very inadvisable to attempt removal of this mass of matted intestine it was decided to anastomose the ileum some inches away from the obstruction with the transverse colon by

[1] THE LANCET, Oct. 26th, 1895, p. 1030.
[2] Annales de Gynécologie et d'Obstétrique, June, 1892.

means of a Murphy's button. This was accordingly done and the union of the two portions of bowel was strengthened by a few Lembert stitches. A Keith's drainage-tube was inserted at the lower end of the wound. The latter was kept in for four days after the operation and gave vent to some sanious discharge only. The child did well after the operation and on the 18th she passed flatus by the rectum. On the 20th a quantity of pus, the source of which was not apparent, passed from the lower end of the wound. There was practically no rise of temperature or fever. The bowels were opened after an enema on the 21st, a week after the operation. The stitches were removed on the 31st. The child by this time had a daily action of the bowels and appeared to be quite well. The Murphy's button, however, had not been passed. On June 25th examination by means of the x rays showed this to be in the right iliac fossa, as if it had fallen back into the ascending colon, and at a consultation on the 26th a second laparotomy was advised, the button to be dealt with according to circumstances. On the 28th (45 days after the first operation) the abdomen was opened in the right semilunar line. There was absolutely no trace of tubercle about the peritoneum; the miliary nodules and the enlarged mesenteric glands seen at the former operation had both absolutely disappeared. The intestines were perfectly healthy in every respect but were firmly adherent in the right iliac fossa. The Murphy's button could be felt deeply placed in this situation and surrounded by adherent intestines. It was therefore resolved to leave it.

The child made an uninterrupted recovery from the operation and was sent in July to the convalescent hospital at Wimbledon. She was under observation there until September and has recently been seen. She seems perfectly well in every respect and suffers no inconvenience of any kind from the Murphy's button.

CASE 2. *Intestinal obstruction caused by malignant disease of the colon; colectomy; recovery.*—A woman, aged 59 years, was admitted into St. George's Hospital on May 13th, 1901. She had been losing flesh for the last four months and had had dyspepsia and constipation. On the 9th vomiting started and had continued until the morning of admission. There were much abdominal pain, referred chiefly to the umbilicus, and swelling. The last natural action of the bowels occurred on the 8th. An enema was administered on the 12th with small result and again on the 13th with no result. The patient's condition on admission was as follows. She was a grey-haired woman with sallow complexion and was obviously wasted; the skin was inelastic and wrinkled. The central part of the abdomen was distended and resonant and active peristalsis of the intestines was seen. There was no rigidity. No tumour could be felt. There was good abdominal movement on respiration. The rectum was capacious and empty; no tumour or stricture was to be felt. Her pulse was 120, the respirations were 28, and the temperature was 97·8° F. Dr. F. G. Penrose saw the case and agreed in advising operation.

Mr. Turner opened the abdomen below the umbilicus in the middle line. The cæcum was enormously distended, the appendix was normal, and the sigmoid flexure was collapsed but otherwise normal. The abdominal incision was now extended upwards to allow of examination of the parts above the umbilicus. The splenic flexure of the colon was then found to be the seat of a tight annular malignant stricture involving about one and a half inches of the bowel. No secondary growths were to be seen. The growth was resected with about one inch of healthy bowel on each side and the ends were sutured, Allingham's bone bobbin being used. A few Lembert stitches were also inserted. Some strips of gauze and a glass drainage-tube were passed down to the seat of resection and a tube was inserted to drain the pelvis. On the 14th the patient was much better. No pain or vomiting was present. There was much serous discharge from the wound. On the 12th she was doing well; all plugging was removed. On the 20th the drainage-tube was removed. A good motion was passed by the bowel. On the 23rd there was some distinct fæcal discharge from the wound (? due to some slight sloughing at the seat of suture). On the 30th she was doing well. There was a slight discharge, no longer feculent, from the wound. The bowels were acting normally and good motions were passed. The patient was being fed on solid substantial food.

Remarks by Mr. TURNER.—The chief interest of Case 1 consists not so much in the intestinal obstruction with the concomitant pseudo-intussusception due to the tuberculous peritonitis as in the rapid disappearance of the tuberculous condition. Enlarged mesenteric glands numbering at least 20 or 30 and multitudes of miliary tubercles had entirely disappeared when the second laparotomy was performed 45 days after the first operation. That such disappearance follows operation is well known, but this case shows how quick that disappearance may be and how soon a diseased intestine and mesentery may recover from tuberculous invasion. Any attempt at dealing with the matted ileum and cæcum with a view to their disentanglement or resection in the child's very grave condition would most undoubtedly, in my opinion, have proved quickly fatal. To use Murphy's button seemed to be the quickest and the safest course to pursue, and although the button has not even yet come away its presence gives rise to absolutely no symptoms. It should have been mentioned that at the first operation a minute perforation was seen in the softened distended ileum which was closed by a Lembert's suture. It was not more than a pin-prick and seemed to follow the application of a Spencer-Wells clip to a bleeding vessel in the neighbourhood. All the lower part of the ileum was reddened, soft, and hooded, as it were, over the cæcum and appendix which were in consequence, except for the tip of the latter, obscured from view. There was little if any fluid in the peritoneal cavity.

In Case 2 colectomy was done during the actual bout of intestinal obstruction which rendered its performance more difficult and led me to use a drainage-tube and gauze packing, as I had not implicit confidence in the condition of the distended bowel which was sutured. I had seen, too, in another case where the bone bobbin was used for a colectomy some slight fæcal leakage afterwards. The depth of the parts operated on would have made direct suture very difficult and have dangerously prolonged the time of operation. The successful issue of the case was largely due to the gauze drainage employed, as there can be no doubt that there was some little leakage from the bowel 10 days after the operation.

For the notes of the cases I am indebted to Mr. T. C. English.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

The Relation of Malignant to Rheumatic Endocarditis.

A MEETING of this society was held on April 8th, Mr. W. J. WALSHAM, the President, being in the chair.

Dr. F. J. POYNTON and Dr. ALEXANDER PAINE communicated a paper entitled, "A Contribution to the Study of Malignant Endocarditis." They had been led to study malignant endocarditis in the course of an investigation upon the pathogenesis of rheumatic fever. The relationship between the two diseases was, they believed, a very close one and this was especially true of certain cases of malignant endocarditis which were associated with a previous history of rheumatic fever and during the course of which rheumatic manifestations were apt to occur. Now that rheumatic valvulitis was known to be infective "malignant endocarditis" was, they thought, a more accurate term than "infective endocarditis." The question arose whether some of these malignant cases were not really rheumatic. The idea was not an original one but the possibility of complete proof had been heretofore impossible since an exciting cause of rheumatic fever had been unknown. The evidence in favour of such a cause being a diplococcus was now extremely strong and this seemed a fit occasion to investigate once more the relationship of these two diseases. The result of the present research had led them to the conclusion *that there was a group of cases of malignant endocarditis rheumatic in origin.* The chief reasons for this conclusion and for which evidence was adduced in this contribution were: (1) that clinical experience favoured the assertion and clinical cases were narrated in support of this statement; (2) that the study of the morbid anatomy of the diseases was also in its favour; and (3) that bacteriological and experimental investigations were also in accord with the view, because a diplococcus could also be isolated from cases of malignant endocarditis which could be grown in pure culture,